

Abuse and Older Persons: Issues and Implications for Counselors

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Counselors can play a vital role in addressing the needs of increasing numbers of older persons subject to and at risk for abuse from their families, caretakers, and themselves.

In the 1960s there was an increasing awareness of the problems of child abuse. In the 1970s people became aware of the issues surrounding spouse abuse, and services were developed to meet the needs of these victims. The 1980s may be considered the era of awareness for "elder abuse" (U.S. Department of Health and Human Services, 1980). Awareness of the abuse of older persons is at the stage that child abuse was 20 years ago (Floyd, 1984). The available evidence suggests that elder abuse is a family phenomenon, with the overwhelming proportion of abuse occurring in the home (Douglass, 1983; U.S. Department of Health and Human Services, 1980).

Neugarten (1979, cited in Eyde & Rich, 1983) described aging in America as a "crisis in slow motion." Elder abuse is one aspect of this developing crisis. In this article we explore violence against the elderly in the home and in institutions. The major areas included are physical violence, neglect, financial exploitation, and psychological abuse by caretakers, whether these caretakers are family members, relatives, or persons employed to care for the frail, older adult.

According to a 1981 report by the U.S. House of Representatives Select Committee on Aging (SCOA), 4% of people over 65 may be victims of abuse, representing over 1 million persons per year. The frequency and rate of such abuse seems to be only slightly less than that of child abuse, but it is much less likely to be reported. One in three cases of child abuse are reported, compared to one in six cases of elder abuse (SCOA, 1981b). Estimates range as high as 2.5 million per year, with perhaps 1 in every 10 older persons living with family members being subject to abuse (Giordano & Giordano, 1984).

DEFINITION AND SCOPE OF THE PROBLEM

There are many factors involved in dealing with abuse of older persons, regardless of the setting in which it occurs. These commonalities include the difficulty in defining abuse (Pedrick-Cornell & Gelles, 1982), the problems in identification of abused persons or those at risk for abuse (Sengstock, Barrett, & Graham, 1984), and difficulties in determining appropriate intervention strategies (Booklin & Cunkle, 1985). There have been several typologies proposed for defining abuse of older persons, with psychological abuse being the more common in each paradigm (Block & Sinnott, 1979; Sengstock et al., 1984). The Select Committee on Aging (1981b) defined the following categories of abuse: physical abuse, negligence, psychological abuse, violation of rights, and self-neglect. In this discussion *abuse* is defined as

"the active physical abuse of an elderly dependent parent [person]" (Giordano & Giordano, 1984, p. 232). Neglect is the mismanagement of the physical and emotional well-being of an older adult. Psychological abuse is the use of active attempts to intimidate or diminish the mental well-being of the individual, and exploitation is the mistreatment of the older individual with regard to his or her financial affairs.

Most data on the abuse of older persons come from commissioned government studies (SCOA, 1981a) and from cases reported to state social service agencies. Lacking mandatory reporting laws (Salend & Others, 1984), many physicians, psychotherapists, and other private health care providers do not report instances of elder abuse (Giordano & Giordano, 1984). Lack of commonality in reporting combined with lack of a common classification system for abuse results in much ambiguity in identifying the type of abuse and the frequency (Kosberg, 1983). There is no doubt that the incidence of elder abuse exceeds currently available data.

In a study by Sengstock et al. (1984), one-fourth of the older respondents suffered physical abuse (e.g., bruises, welts, abrasions, beatings, lack of food or personal care), one-half suffered financial abuse (e.g., theft or misuse of property and finances), and more than one-half suffered psychological abuse (e.g., verbal assault, threat, fear, isolation). In their survey, Block and Sinnott (1979) found that psychological abuse was most common. Most instances are recurring (SCOA, 1981b).

CHARACTERISTICS OF OLDER PERSONS ASSOCIATED WITH ABUSE

Although the lack of common definitions of abuse makes it difficult to determine the type and extent of abusive incidences, the characteristics of the victim and the abuser are consistent. Therefore, in this section we provide a brief description of the older population with a focus on salient factors that are correlated with abuse.

In an analysis of studies on elder abuse, the Select Committee on Aging (1981b) concluded that:

The victims are likely to be very old, age 75 or older. Women are more likely to be abused than men. The victims are generally in a position of dependency—that is, they are relying on others (and generally on those who abuse them) for care and protection. (p. 122)

The victim is also most likely to be a White, middle-class person living with an adult child (Block & Sinnott, 1979). Typically, the abuser is a middle-aged, female child who is the primary caretaker. Neither victims nor abusers tend to seek outside help for the abuse (Eyde & Rich, 1983).

Sex

Most older persons are female, with increasing proportions of women in each successive age group after 65, due primarily to the longer life span of women—78 years as opposed to 70 years for men. Most older women are widows (51%), whereas only 17% of older men are widowers (SCOA, 1984).

Age

As the population ages, the proportion of frail elderly, those older persons who are most disabled and most in need of care, is increasing even more rapidly. The over-75 segment is the most significant growth group in American society (American Association of Retired Persons [AARP], 1985), and this group is the most vulnerable to abuse.

Physical and Emotional Impairment

As shown in Table 1, estimates of the percentage of older persons needing functional assistance range from 13% for those ages 65–74 to almost 50% for those age 85 and over. These restrictions may include inability to bathe, cook, dress, or perform personal chores (AARP, 1985). In addition to these impairments, older adults are more likely to have one or more periods of restricted activity because of illness or injury, with older women averaging 35 days of impaired activity per year. Although research has shown that most older persons are in reasonably good health, 86% of those over 65 suffer from one or more chronic physical impairments that limit some aspect of their daily activities (Butler & Lewis, 1983). These impairments, which require assistance in activities of daily living, may place them at greater risk for abuse.

Whereas the so-called "frail elderly" suffer from physical impairments, another group suffers from emotional impairments. Estimates of those older persons in need of mental health services are as high as 25% (Butler & Lewis, 1983). Steinmetz and Amsden (1983), in their survey of volunteers who were providing care to an elderly adult, concluded that social, emotional, and mental health dependencies were closely associated with violence and abuse.

Living Arrangements

Of those older persons who live in family settings, most are men (83%); only 57% of older women live with families. Women

constitute 80% of older persons living alone, or 6.4 million. The 2% of older persons who live with nonrelatives include those in foster or boarding home situations or adult congregate living facilities.

Sources of Assistance

For those older persons who become impaired to the point of needing assistance, the continuum of care available has many gaps. In many communities the choice is home care by a relative or institutionalization. Older men needing care for various infirmities are likely to receive it from a spouse, whereas women needing care are more likely to be living alone and turn to relatives or institutions for care. It is no surprise that older persons fear incapacity and loss of independence (Harris & Others, 1975).

FACTORS CONTRIBUTING TO ELDER ABUSE

Factors that contribute to elder abuse include many of the same factors associated with family violence in general. Obviously, the causes are complex, and they may be discussed in terms of four categories identified by Henton, Cate, and Emery (1984): (a) personal characteristics of the abuser and of the abused, (b) interpersonal characteristics of the relationship between the abuser and the abused, (c) situational factors that increase the likelihood of abuse, and (d) sociocultural factors that impinge on the use of violence. Personal characteristics of the victim and of the abuser were discussed above; in this section the focus is on additional factors relative to the abusive situations.

Personal Factors

Some cases of elder abuse do occur in homes with a lifelong pattern of violent relationships, such as ongoing spouse abuse or prior instances of child abuse. The cycle of violence explanation suggests that abused persons have learned to use abuse as a means of tension reduction in response to stressful situations. Steinmetz (1978) noted that 1 in 400 children who are reared nonviolently attack their parents later in life, compared to 1 in 2 children who are abused by their parents.

Older persons who are or who perceive themselves to be helpless and dependent are the most likely targets for abuse (Henton et al., 1984). Physical and mental impairments combine to increase their vulnerability. When the older person is confused, the stress on the caregiver and potential for random instances of abuse are increased.

The Steinmetz and Amsden (1983) survey suggested that abusive behavior of the older adult toward the caregiver added to the stress of the caretaker. In their sample, caregivers reported that 19% of older persons used force, such as slapping or hitting. Mental health dependency of the older person, resulting in a need for help to avoid getting lost and help with decision making and forcing caregivers to deal with nonrational or explosive behavior of the elderly person, was highly correlated with abusive behavior by caregivers and other family members.

Interpersonal Factors

Interpersonal factors may include a variety of unresolved past conflicts and lifelong histories of inadequate relationships. Power conflicts may contribute to abuse (Henton et al., 1984), as may failure to resolve the filial crisis (Block & Sinnott, 1979). Adults providing support may believe that they are not receiving enough gratification for their efforts, leading them to be abusive (Giordano & Giordano, 1984).

Situational Factors

Situational factors relate to the increased stress involved with the addition of yet another family member, especially one who is dependent. The middle-aged abuser is described as being in the "sandwich generation," providing care both to children and to the older adult (Dobson & Dobson, 1985). This situation oc-

TABLE 1
Characteristics of the Population Over 65

	Numbers (in millions)	Percentage
<i>Age</i>		
Over 65	28	
65–74	16.7	59
75–84	8.6	31
85+	2.7	10
<i>Sex</i>		
Females	16.7	60
Males	11.3	40
<i>Noninstitutionalized Adults Over 65</i>		
<i>Living Arrangements</i>		
With family	17.7	67
Alone	8.0	30
With child	4.8	18
With nonrelatives	.53	2
<i>Physical Impairments</i>		
Need assistance	4.8	19
65–74	2.2	13
75–84	1.2	25
85+	1.2	46
Institutionalized	1.3	5

Adapted from *A Profile of Older Americans* (AARP, 1985).

curs at a time when the caretaker is facing or looking forward to such developmental challenges as the empty nest or developing a postponed career (Giordano & Giordano, 1984). Other situational factors may include the stress of unemployment (Shelton, 1985), substance abuse by the abuser, marital problems, economic difficulties related to providing care for the victim or other financial stress, the stress of providing constant care, and medical problems (Bergman, 1981).

Sociocultural Factors

Sociocultural factors include pervasive, negative attitudes toward older persons, which contribute to feelings of low self-worth by older persons (Butler & Lewis, 1982). The trend toward smaller families, along with geographic separation of family members, results in greater strain for the caregiver (Henton et al., 1984). Few communities have adequate resources to support caregivers who are providing home services to a dependent older adult.

In short, the causes of elder abuse are numerous, complex, and interactive. Although we may have only touched the tip of the iceberg in terms of incidence and causes, abuse of older persons in all instances may be defined as a violation of rights (SCOA, 1981a). Factors to consider in determining causes include retaliation, ageism and violence as a way of life, lack of close family ties, lack of community resources, lack of financial resources, mental and emotional disorders, unemployment, history of alcohol and drug abuse, environmental conditions, resentment of dependency, increased life expectancy, and other situational stress (SCOA, 1981a).

Regardless of the setting, most abused older persons have in common a reluctance to report the abuse "for fear of retaliation, exposure of their sons or daughters to legal punishment, or removal from the only homes they know" (Anderson & Thobaben, 1984, p. 8). The frail older person with multiple impairments is at highest risk for abuse in all settings (Fulmer & Cahill, 1984).

INTERVENTION

Most services to older persons are targeted toward those who live alone or in institutions (Giordano & Giordano, 1984) and, thus, fail to address the issue of abuse in the family setting. Intervention techniques and prevention strategies to date have focused primarily on educational efforts and use of social services. Most experts (e.g., Block & Sinnott, 1979; Steinmetz & Amsden, 1983) have recommended educational efforts for the caregiver and the family. "Families need to understand the developmental characteristics of aging and accurately assess the limits of their ability to provide care" (Steinmetz & Amsden, 1983, p. 191).

The Flint, Michigan Task Force on Elder Abuse (Cherry & Allen, 1983) identified four problems in the effective handling of elder abuse: (a) a general lack of knowledge and understanding about the aging process, (b) a lack of awareness of the dynamics of elder abuse among both professionals and caregivers, (c) a lack of knowledge of ways to assist families with cases of abuse and to mobilize support networks for assisting families in crisis, and (d) a lack of family awareness of how to care for older persons who are dependent on them.

Formal intervention strategies include providing support to families through the use of various programs and services for the elderly. As noted by Bergman (1981), flexible services to meet the needs of the victims are not always available. Meals-on-wheels, respite care, or other community services may be needed to relieve some stress on the caregiver, or protective placements such as domestic violence shelters may be used to provide temporary relief.

Legal actions may include restraining orders or criminal charges against the abuser, although these procedures are seldom im-

plemented. Victims frequently will not press charges for fear of reprisal, fear of loss of home, or embarrassment over the situation. Many older adults will protect their children. Ethical issues regarding the right of older persons to self-determination make it difficult for professionals to act without the willingness of the victim to file a complaint.

Institutionalization is greatly feared by older persons and tends to arouse guilt among caretakers. Thus, it is often a last resort. As with child abuse, the removal of the older adult from the home may be viewed as more of a punishment than as a solution by the victim (Bergman, 1981). Some of the issues in abuse on institutionalized older persons are addressed below.

ABUSE OF OLDER PERSONS IN INSTITUTIONAL SETTINGS

It would seem that reporting of abuse in institutional settings, in contrast to community and, therefore, less well-controlled environments, would be much more precise. This is not the case, however. Most of the literature on abuse deals with family situations, with the admonition that other types of abuse may occur, but abuse within the family is of singular importance (U.S. Department of Health and Human Services, 1980). On the other hand, older persons in institutions are the most frail of the frail elderly, and the frail elderly are the most common targets of abuse. If we consider quality of life for those who are most dependent, the issue of institutional abuse becomes increasingly important.

The available information concerning institutional abuse is both indirect and direct. Indirectly, abuse is implied from studies of selective mortality, in which depressed and self-destructive older persons in nursing homes are more likely to die than are those with higher life satisfaction (Reynolds & Nelson, 1981).

Direct abuse in institutions may involve all of the types of abuse noted in the section on family violence. What is reported in the literature, however, is related to abuse of medications. An estimated 25% of drugs are given in error. Medication abuse also includes overmedication. Older persons in institutions take an average of 10 to 12 drugs per day, in contrast to 4 to 7 per day for older persons living in communities. Of nursing home patients, 95% use prescribed drugs. Depression is a major side effect of many medications given to them, and drug interactions and adverse reactions are common. Overtranquillization is a significant problem (SCOA, 1980).

Contributing Factors

Lack of education of caregivers is a major difficulty in medication abuse (Lamy, 1984). In general, education of nursing home caregivers, including physicians, is needed to reduce the incidence of all kinds of abuse. It is difficult if not impossible to separate active from passive abuse in institutional environments. If passive abuse includes the failure to provide activities for improving the quality of life, then such abuse is widespread in the long-term care system.

Identification of Persons at Risk

As is true of abuse in family environments, the most frail persons are the most probable targets of abuse. Most abused elderly persons are female, over 75, and White. Most nursing home residents are female, over 75, and White. Depressed residents are at risk for self-neglect, in addition to neglect by staff, and may include over 50% of all nursing home residents (Fry, 1986).

Intervention Techniques

As with family abuse, educational efforts have been the primary interventions to date. Training programs for health care staff help prevent institutional abuse (Anderson & Thobaben, 1984). Optimally, training will include communication skills for all long-term care staff (Myers, 1981).

Difficulties in Determining Intervention Strategies

Fitting (1986) and Kemp (1984) described the complexity of the ethical issues involved in serving older clients. The *Ethical Standards* of the American Association for Counseling and Development (AACD) (1981) include a clear statement of the position regarding overt suicide in which there is a danger to self. The issue of client autonomy versus counselor beneficence, however, becomes the central issue in the less overt behaviors of some older adults. What is an abusive situation to a professional counselor may not be considered abusive by the older victim. Does neglect include failure to make an older adult follow a diet specialized for a given health condition? As adults, we all do some things that are detrimental to our health, and no one intervenes directly. As we age, however, we are vulnerable to many direct interventions, including having food denied (whether it is part of a prescribed diet or not, such as salt or chocolate) or having restraints applied (for an older person who is confused and may tend to wander). These conditions, although necessary in some circumstances, may be classified as abusive behaviors in other circumstances.

Knowing when to intervene is not an easy question with many older persons. Counselors may find some guidelines in ethical codes and in statements of rights, including the rights specified in the *Bicentennial Charter for Older Americans* (Federal Council on Aging, 1976). These rights include the right to life with dignity as well as death with dignity. Counselors often may find themselves in the role of advocate for older persons, and they should have access to applicable statements of rights to assist these persons. An explanation of rights to older persons and their caregivers may lead to fruitful discussions and improved life-styles for both.

CONCLUSION

A major difficulty in work with older persons and their families is the prevalent lack of knowledge concerning the aging process and lack of preparation for eventual care of an aging parent. Care giving in any situation is stressful, and it becomes increasingly so in the absence of preparation (Henton et al., 1984). Counselors can assist older people and their families by providing accurate information and resources for learning about aging. Self-help books for older persons (e.g., Skinner & Vaughn, 1986) and their families (e.g., Cicirelli, 1981; Kenny & Spicer, 1984) are available. Interested persons may obtain a copy of an annotated bibliography of resources for understanding aging parents (Bressler, 1982).

Expansion of the support network for individual older persons will help to provide relief and respite for family members responsible for their care. Similarly, expansion of the support networks for family members will provide needed relief valves for tension and stress. Techniques for enhancing positive interactions and dealing with stress may be taught by counselors in support group settings and in individual counseling. Assertive training for both older persons and their caregivers may be helpful.

Counselors working with older persons and their families must be alert to risk factors for abuse and self-abuse and must follow up on their hunches to intervene and prevent further violence. Both individual and group treatment approaches will be helpful, along with advocacy efforts aimed at community interventions. Because of the paucity of research on causes of abuse among older persons (Giordano & Giordano, 1984), we recommend that counselors in the field maintain data bases and share this information with other professionals.

As is evident in Table 2, the percentage of persons over the age of 65 has increased dramatically in this century. Today, 1 in every 9 Americans is over 65. This is in marked contrast to

TABLE 2
Growth Rates of the Over-65 Population as Percentage of U.S. Total Population 1900-2050

	1900	1985	2000	2050
Over 65	4%	12%	15%	20%

Adapted from *A Profile of Older Americans* (AARP, 1985).

the situation at the turn of this century, when only 1 in 25 was over the age of 65 (SCOA, 1984). By the year 2000, more than one-half of the population will be over age 50 (Butler & Lewis, 1983); by 2050, one-fifth will be age 65 and above (SCOA, 1984). It is clear that the concerns now faced for older persons, whatever they may be, are likely to increase in proportion based on the ever-increasing numbers of older people.

Henton et al. (1984) noted that persons of any age

who develop patterns of excessive dependence in relationships often find themselves at a serious disadvantage. When such dependence causes them to feel they cannot function without the presence or attention of a limited few, they suddenly become at risk of tolerating unacceptable behavior directed toward them by those selected persons. (p. 149)

Because of physical and mental impairments, many older persons of necessity develop such dependent relationships, placing them at risk for various kinds of abuse. Normal age-related changes may lead to dependence. This, along with role losses, depression, and fears of dependence may lead to self-abuse, including suicide, or toleration of abusive behavior by others. As discussed above, physical and emotional impairments do increase with age, placing those over the age of 75 in great danger of developing dependent relationships.

Given the relationship of elder abuse to child abuse, the cycle of violence, coupled with the rapidly expanding proportion of dependent, elderly individuals, suggests that instances of elder abuse will spread. Intervention strategies that help to break this cycle are needed, and there must be preparation by counselors and social service agencies to deal with abuse of older persons. Alternatives to institutionalization, development of respite care programs and adult day care facilities, and education of families about the impact of age-related disabilities will be needed for many years to come. Counselors must prepare for advocacy work on behalf of older persons and must work with the older individual and his or her family.

Several studies have shown that the public at large is unaware of and unconcerned about abuse of older persons (Chen et al., 1981). A contributing factor is the nature of the social service system, which has used institutionalization as the dominant form of care to protect and treat older adults (Giordano & Giordano, 1984). Current trends toward deinstitutionalization and community care of older persons, combined with increases in the older population, will probably result in more demands on family and community caregivers. Thus, the potential incidence of abuse of older persons may increase. Counselors must be prepared to recognize and treat abusive situations, not just in a reactive sense but proactively as well. Concern for improving the quality of life and the coping skills of adults and older persons will be required of all in the helping professions to meet the challenges that lie ahead.

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